



3850 E 300 N  
RIGBY, ID 83442  
208-745-6693

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2020 - 2021  
Benefit Summary

*YOUR GUIDE.*

*YOUR ADVOCATE.*



## 2020 Jefferson School District, #251, Contact Sheet

Blue Cross of Idaho - Medical, Dental & Vision  
Group #10003738  
[www.bcidaho.com](http://www.bcidaho.com)

1-800-627-1188

LifeMap - Life  
Group # WBT000674  
[www.lifemapco.com](http://www.lifemapco.com) 1-800-794-5390

Teladoc - Telemedicine  
Group ID # 39835  
[www.teladoc.com](http://www.teladoc.com)

1-800-835-2362

NBS Benefits- MERP / Buy Down  
<http://my.nbsbenefits.com> 1-855-399-3035

Your American Insurance / GBS of Idaho team is available to answer any questions:

Travis Argyle	<a href="mailto:travis.argyle@gbsbenefits.com">travis.argyle@gbsbenefits.com</a>	208-529-3541
AJ Argyle	<a href="mailto:aj.argyle@gbsbenefits.com">aj.argyle@gbsbenefits.com</a>	208-529-3541
Magen Smith	<a href="mailto:magen.smith@gbsbenefits.com">magen.smith@gbsbenefits.com</a>	208-529-3541

### Welcome!

To help educate you on the many benefits Jefferson School District #251 offers, please review the following 2020-2021 benefit materials. If you have any questions about your benefits, we are here to help.

### Human Resources

Please contact Human Resources or our broker, GBS of Idaho, for any benefits related questions, including benefit coverage, contributions, enrollment, benefit change forms, notification for changes in status, provider directories, and general carrier information.

### Social Security Numbers

Federal law requires you to provide a valid Social Security number for each person to be covered by any medical plan sponsored by your employer (yourself, your spouse, and all dependent children).

### Medicare Part D

If you have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. See Human Resources for more information.

### HIPAA Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) requires employers to adhere to strict privacy guidelines and establishes employees' rights with regard to

their personal health information. If you have any questions regarding this federal regulation, please speak with your Human Resources representative.

### IRS Regulations

Failure to meet IRS deadlines will affect your insurance coverage! IRS regulations govern how and when an employee may make cafeteria plan elections and changes to those elections. These rules require that employers enforce firm deadlines with respect to employee benefit enrollment and the related cafeteria plan elections. This means that we cannot accept forms turned in after open enrollment ends. Furthermore, if you experience a qualifying event allowing you to add, drop, or modify your coverage and related cafeteria plan election mid-year, we must be notified of such event. The required forms generally must be completed within 30 days of such event, or you cannot make the change. In addition, please be aware that the exception of the birth, adoption, or placement for adoption of a child, any cafeteria plan election change can only be implemented prospectively, i.e., on the first paycheck or period of coverage following our receipt of the form. Therefore, if you are making a change based on a qualifying event other than a new child, and you want changes implemented as of the date of the event, you must inform us of the change in advance. **If you do not enroll on time, you will not receive coverage or be able to change your elections mid-year unless you have a special enrollment opportunity.**

**NOTE:** This publication is only a partial summary of benefits and is provided for informational purposes only. It does not describe all elements of the summarized programs. For complete information regarding the benefits, plan provisions, limitations and exclusions, and for a description of claims procedures, refer to the formal benefit documents that will be provided to you after enrollment. In the event of a discrepancy or conflict between the information contained in this publication and the official benefit plan provisions, the official plan documents and insurance contracts will govern. Copies of these documents are available for your review from your Human Resources department or as provided by GBS of Idaho. No rights shall accrue to you and/or your dependents because of any statement, error, or omission in this publication.

## ENROLLMENT GUIDELINES: 2020 – 2021

### Why is open enrollment so important?

Benefits open enrollment for Jefferson School District #251 is held each year. Employees should understand that the pre-tax payment for applicable benefits are done through the Cafeteria Plan (premium only plan) and will remain in effect and cannot be revoked or changed during the plan year. Once the enrollment period has ended, employees may not make or change benefit elections unless they experience a qualifying event. Employees must notify Human Resources of any change of status as soon as possible, but in no event more than 30 days after the event. The employee generally has 30 days to complete and return a new enrollment form to make or change benefit elections due to a qualifying change in status.

### Who is eligible to participate in the benefit plans?

1. Eligible Employee: to qualify as an eligible employee under this policy, a person must be an employee who regularly works at least thirty hours per week;
2. Eligible Dependent:
  - The Enrollee's spouse under a legally valid marriage.
  - The Enrollee's natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption, or child for whom the Enrollee or the Enrollee's spouse has court-appointed guardianship or custody. The child must be:
    - Under the age of twenty-six (26); *or*
    - Medically certified as disabled due to intellectual disability or physical handicap and financially dependent upon the Enrollee for support, regardless of age.
3. An Enrollee must notify the Group within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility occurred.

### Is it possible to make changes during the year?

After the enrollment deadline, your election is generally irrevocable, meaning you cannot add, modify, or drop coverage for the plan year. You may have a special enrollment right allowing coverage changes for certain losses of coverage eligibility under another plan, or if you gain a new spouse or dependent. You also may be entitled, or required, to change your election if you, your spouse, or dependents experience one of the qualifying events below. However, you must contact Human Resources to determine if your plan and your circumstances allow such a change. If so, you must complete and submit the change generally within 30 days.

### Qualifying Changes: (30 Days Unless Otherwise Stated Below)

- Marriage, divorce, or legal separation; or change in number of dependents;
- Change in employment status of employee, spouse, or dependent that causes loss of eligibility;
- Dependent ceases to satisfy eligibility requirements;
- Change in residence that causes loss of eligibility;
- Significant changes in company benefit plan(s), including cost change, significant coverage curtailment, additional or significant improvement of company offered benefits;
- Change in coverage under another employer plan (including mandatory or optional change initiated by spouse's employer or a change initiated by your spouse);
- Loss of coverage from governmental plans / programs or educational institution;
- COBRA qualifying event (termination / reduction of hours, employee death, divorce / legal separation, ceasing to be a dependent);
- Other changes resulting from a judgement, decree, or order; Medicare or Medicaid entitlement; or FMLA leave of absence;
- Loss of CHIP or Medicaid eligibility; gaining CHIP or Medicaid subsidy eligibility (60 days).

#### Glossary of Terms

**Co-pay:** Typically refers to a dollar amount a member pays for services.

**Deductible:** Amount that must be paid by the member prior to the benefits offered and are indicated with AD (After Deductible).

**Coinsurance:** Typically refers to the percentage of a member's share of covered costs, after any deductible has been satisfied.

**Out-of-Pocket Maximum:** The maximum amount members pay for covered in-network essential health benefit expenses during the benefit year, including co-pays, coinsurance, and deductible.

**PPO (Preferred Provider Organization):** This type of plan utilizes network and non-network benefits.

**Network (In-network):** Providers who have agreed to accept contracted rates from an insurance carrier.

**Non-Network (Out-of-Network):** Any non-contracted provider. The services from these providers are subject to balance billing, meaning members can be billed for the difference between the insurance carrier's fee schedule and the billed charges.



## Jefferson School District #251 New Dual Option Medical Plan Offering Comparison

* Benefits assume In-Network Providers and Wellness Qualification.	<b>*Traditional PPO Plan New Plan Offering</b>	<b>New H.S.A. (Health Savings Account) New Dual Plan Option</b>	
<b>Deductible Buy Down</b>	\$500 Ind/ \$1,000 Fam.		
<b>Co-insurance Buy Down</b>	80%		
<b>Carrier Deductible</b>	\$3,000 Ind/\$6,000 Fam.	\$6,800 Ind./ \$13,600 Fam.	
<b>Carrier Co-Insurance</b>	70%	100%	
<b>TOTAL OUT OF POCKET</b>	<b>\$2,500 Ind./\$5,000 Fam.</b>	<b>\$6,800 Ind./ \$13,600 Fam.</b>	
<b>Prescription Drug- Retail</b>	<b>\$10/\$20 Co-Pay- Generic \$250 Deductible \$30/\$50 Co-Pay- Name Brand \$20%/30% Co-Pay- Speciality</b>	100% Coverage For Listed Preventive RX's  All other Prescription Drugs go towards Deductible	
<b>Prescription Out Of Pocket</b>	\$2,000 (Separate from Medical Out of Pocket)	Goes towards Medical Out of Pocket	
<b>Dr. Co-Pay General</b>	\$10 Choice Dr's/ \$30 non Choice	100% After Deductible is met.	
<b>Dr. Co-Pay Specialist</b>	\$30 Choice Dr.'s/ \$50 non Choice	100% After Deductible is met.	
<b>Wellness/ Preventive (Please refer to attached listing)</b>	100% No Deductible	100% No Deductible	
<b>Immunizations (Please refer to attached listing)</b>	100% No Deductible	100% No Deductible	
<b>Diagnostic Lab/X-ray</b>	First \$100 is covered then Deductible	Deductible First	
<b>Below Rates include Medical, Vision, Dental and Life coverage.</b>			
			<b>District H.S.A. Contribution</b>
Enrollee	\$0.00	\$0.00	<b>\$100.00</b>
Ee / Spouse	\$657.24	\$378.10	<b>\$100.00</b>
Ee/Child	\$236.10	\$65.75	<b>\$100.00</b>
Ee/Children	\$430.36	\$218.80	<b>\$100.00</b>
Family	\$937.47	\$600.65	<b>\$100.00</b>

*Please refer to contract for full benefits listing. Blue Cross Contract supersedes this summary. This is a brief summary of benefit for comparison purposes*

# HSA PREVENTIVE DRUG LIST

You Make the Choices, We Make it Easy

If your Benefit Summary indicates specific coverage for preventive drugs, the Preventive Drug List provides the drugs you can obtain under this benefit. Plans that have specific preventive drug benefits are generally:

- High Deductible Health Plans (HDHPs) or Health Savings Account (HSA) plans
- Employer plans that have purchased an HDHP/HSA plan **OR**
- Employer plans that have purchased a preventive drug enhancement

Blue Cross of Idaho covers the drugs on this list at the preventive drug cost-sharing amount found in your plan documents, and you do not need to have met your deductible when you get these prescriptions filled at an in-network pharmacy.

## FOR OUR MEMBERS:

- Visit an in-network pharmacy to receive this benefit.
- Present your Blue Cross of Idaho member ID card to ensure you receive the complete benefit.
- You or your doctor may be asked to provide supporting documentation that the drug you are taking is being used for prevention.

## FOR OUR HEALTHCARE PROVIDERS:

- Please prescribe preventive drugs from this list and allow generic substitutions when medically appropriate.

**NOTE:** A drug's appearance on this list does not guarantee coverage. Not all drugs listed are covered by all prescription drug plans. Certain drug plans may cover additional drugs at a preventive benefit that are not listed below. Check your benefit materials for the specific drugs covered and the cost-share information for your prescription-drug benefit program. This list may not include all prescription drugs intended for preventive purposes. This list is periodically reviewed by clinical experts. Medications may be added or removed from this list based on clinical review of the medication's intended purpose and its availability.

## HOW TO USE THIS LIST:

Generic drugs are listed in lower case letters, example: atenolol. Generic medications contain the same active ingredients as their corresponding brand-name counterparts; though they may look different in shape and color, they have been FDA-approved under the same strict standards.

Brand-name drugs are listed in CAPITAL letters, example: NOVOLOG. When brand-name drugs lose their patents and become available generically, only the generic equivalent will be eligible under this preventive benefit.

<b>ANTIDEPRESSANTS</b>		
citalopram tablets	fluoxetine capsules	sertraline tablets
escitalopram tablets	paroxetine immediate-release tablets	venlafaxine immediate-release tablets
<b>ASTHMA</b>		
ADVAIR HFA	fluticasone propionate-salmeterol inh	SPIRIVA
ASMANEX	ipratropium soln	SPIRIVA RESPIMAT
ASMANEX HFA	ipratropium-albuterol soln	SYMBICORT
budesonide susp	levalbuterol	terbutaline
COMBIVENT RESPIMAT	montelukast	theophylline
cromolyn sodium soln	PULMICORT INH	theophylline ER
FLOVENT DISKUS	QVAR REDHALER	zafirlukast
FLOVENT HFA	SEREVENT	
<b>BLOOD PRESSURE-LOWERING MEDICATIONS</b>		
<b>ACE Inhibitors &amp; Diuretic Combinations</b>		
benazepril	fosinopril	olmesartan medoxomil
benazepril-HCTZ	fosinopril-HCTZ	olmesartan medoxomil-HCTZ
captopril	lisinopril	quinapril
captopril-HCTZ	lisinopril-HCTZ	quinapril-HCTZ
enalapril	moexipril	ramipril
enalapril-HCTZ	moexipril-HCTZ	trandolapril
<b>Angiotensin Receptor &amp; Diuretic Combinations</b>		
candesartan	irbesartan-HCTZ	telmisartan-HCTZ
candesartan-HCTZ	losartan	valsartan
eprosartan	losartan-HCTZ	valsartan-HCTZ
irbesartan	telmisartan	
<b>Beta Blockers &amp; Diuretic Combinations</b>		
acebutolol	labetalol	propranolol SR
atenolol	metoprolol succinate ER	propranolol-HCTZ
atenolol-chlorthalidone	metoprolol tartrate	sotalol
betaxolol	metoprolol-HCTZ	sotalol AF

### THIS LIST IS SUBJECT TO CHANGE.

Check your benefit materials for cost-share information.

For specific questions regarding your coverage, please call the phone number printed on your member ID card.

bisoprolol	nadolol	timolol
bisoprolol-HCTZ	pindolol	
carvedilol	propranolol	
<b>Calcium Channel Blockers</b>		
afeditab CR	diltiazem SR	nifedipine osmotic
amlodipine	felodipine SR	verapamil
diltiazem	isradipine	verapamil CR
diltiazem CD	nicardipine	verapamil SR
diltiazem ER	nifedipine	
diltiazem LA	nifedipine ER	
<b>Diuretics (water pills)</b>		
amiloride	eplerenone	spironolactone
amiloride-HCTZ	furosemide	spironolactone-HCTZ
bumetanide	hydrochlorothiazide (HCTZ)	torsemide
chlorthalidone	indapamide	triamterene-HCTZ
chlorothiazide	metolazone	
<b>Other Blood Pressure-Lowering Medications &amp; Combinations</b>		
amlodipine-atorvastatin	clonidine	methyl dopa
amlodipine-benazepril	clonidine patches	minoxidil
amlodipine-valsartan	guanfacine	telmisartan-amlodipine
amlodipine-valsartan-HCTZ	hydralazine	trandolapril-verapamil
<b>BLOOD THINNING AGENTS</b>		
anagrelide	clopidogrel	warfarin
cilostazol	pentoxifylline	
<b>CHOLESTEROL-LOWERING MEDICATIONS</b>		
<b>Statin/HMG CoA Reductase Inhibitors &amp; Combinations</b>		
atorvastatin	lovastatin	rosuvastatin
fluvastatin	pravastatin	simvastatin
<b>Other Cholesterol-Lowering Medications</b>		
cholestyramine	ezetimibe	fenofibrate
cholestyramine light	ezetimibe-simvastatin	fenofibrate, micronized
colestipol	fenofibric acid	gemfibrozil
<b>DIABETES</b>		
acarbose	LANTUS	pioglitazone-metformin
FIASP	LEVEMIR	repaglinide
glimepiride	metformin	RYBELSUS (ST, QL)
glipizide	metformin ER	SYMLINPEN
glipizide extended release	nateglinide	TRESIBA
glipizide-metformin	NOVOLIN (Not including Novolin Relion Products carried at Walmart Pharmacies)	TOUJEO
glyburide	NOVOLOG	TRULICITY (ST, QL)
glyburide, micronized	OZEMPIC (ST, QL)	VICTOZA (ST, QL)
glyburide-metformin	pioglitazone	
HUMULIN-R 500	pioglitazone-glimepiride	
<b>Diabetic Supplies</b>		
BD Lancets	insulin syringes	ONETOUCH Lancets
insulin pen needles	NOVOFINE Lancets	ONETOUCH test strips (QL)
<b>OSTEOPOROSIS</b>		
alendronate (QL)	ibandronate (QL)	risedronate (QL)
<b>WOMENS HEALTH</b>		
<b>Breast Cancer Prevention</b>		
raloxifene (AL)	tamoxifen (AL)	
<b>Birth Control</b>		
All generic oral contraceptives	Medroxyprogesterone acetate (IM) (QL)	Xulane (generic Ortho-Evra)
DIAPHRAGMS (QL)	etonogestrel/ethinyl estradiol ring (QL)	
<b>Birth Control (Emergency Contraception)</b>		
All generic emergency contraceptives	ELLA	
<b>Thyroid</b>		
levothyroxine tablets		
<b>VACCINES</b>		
FLU	PNEUMONIA	SHINGLES (AL)

**THIS LIST IS SUBJECT TO CHANGE.**

Check your benefit materials for cost-share information.

For specific questions regarding your coverage, please call the phone number printed on your member ID card.



## YOUR PATH TO BETTER HEALTH BEGINS NOW.

We value you and what you offer. Your success is our success, and we want to make sure you have every chance to improve your health. Because of this, we hope you take advantage of the **Healthy Measures** wellness program.

It has often been said, "When you have your health, you have everything." Taking part in **Healthy Measures** can help improve your health and save you money!

Beginning June 1, 2020, you can qualify for the **Healthy Measures** program and be rewarded with a \$500 individual deductible (\$1,000 family deductible).

We hope that everyone will take part in **Healthy Measures** by November 30, 2020.

### What is **Healthy Measures**?

**Healthy Measures** is Jefferson School District's wellness program. Every year, employees who are covered by the district's medical benefits can participate and earn a valuable reward. Spouses are not required to participate.

Since the start of our wellness program, Jefferson School District has always wanted you to "know your numbers" to help you understand your overall health. To do this, we encourage you to visit your doctor for an annual wellness visit and give you access to Blue Cross of Idaho's health coaches, personal trainers and registered dietitians and the WellConnected wellness portal. Plus, when you take part in the quarterly wellness challenges, you have the chance to win prizes, like a FitBit activity tracking device or Visa gift card.

### What do I have to do?

**Healthy Measures** encourages you to meet with your doctor for a preventive health visit or fill out the health questionnaire form (HQF). Starting this year, Blue Cross of Idaho will be looking through claims for preventive care visits. If you've had a preventive exam after June 1, 2020, you will automatically fulfill the requirement for the HQF. See your doctor for a preventive health visit or submit the HQF and you will qualify for the reward.

### Tell me about the reward.

To encourage you to take part in the **Healthy Measures** program, the district will buy down your individual deductible to \$500 (\$1,000 for family).

If you choose not to join in the **Healthy Measures** program, the district will buy down your individual deductible to \$1,000 (\$2,000 for family).

Whether you are already in good health or need to improve your health and are willing to try something new, you can join in and be rewarded.



## WHAT DO I NEED TO DO?

Have a Preventive Care Exam or Complete the HQF.

The preventive visit helps you and your doctor measure your health. The HQF focuses on five key health areas: tobacco use, blood pressure, cholesterol, weight and blood sugar. This is what you'll need to do:

- Make an appointment with your doctor for a preventive care visit. If you don't have a doctor, this is a great time to establish a relationship with one.\* Your preventive care visit is covered at 100% if billed as a wellness visit by your in-network doctor.
- Tell your doctor's office you will need lab work for cholesterol and blood sugar tests. You may be able to have the blood work done prior to your appointment, and you should be fasting. This may also be fully covered if you see an in-network provider.
- Fill out the HQF with your doctor; ask questions and make a plan of ways to improve your health, if necessary.
- Send the completed form to Blue Cross of Idaho no later than November 30, 2020. (Refer to the instructions on the back of the HQF on how to submit your form.) You will get a letter to let you know if you qualify. Or, you can check your status in the wellness portal.

\* You can find a list of local providers on the Blue Cross of Idaho website at [bcidaho.com](http://bcidaho.com) or contact their customer service department for assistance.

Blue Cross of Idaho		Jefferson School District Health Qualification Form	
<b>Member Information (complete and sign)</b>			
Member Name (Please print)		Blue Cross of Idaho Subscriber ID Number (9 digit number)	
Date of Birth (mm/dd/yyyy)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number	
Employer Group Name <b>Jefferson School District</b>		Group Number <b>10003738</b>	Email Address
Member Signature		Date	
This program includes health coaching. Please call 855-216-6844 to work with your certified health coach.			
<b>Healthcare Professional providing this service (complete and sign)</b>			
Provider Name (Please print)		Telephone Number	State License Number or National Provider ID (NPI)
Provider Signature		Date	
Healthcare Provider: Please provide your information above and complete the health measures below.			
Health Measure	Initial Evaluation	Values (Required)	
<b>Tobacco Use</b> (Tobacco use includes tobacco cigarettes, smokeless tobacco and e-cigarettes)	Check one (required): <input type="checkbox"/> No <input type="checkbox"/> Yes Patient has not used tobacco for three consecutive months prior to assessment date	Assessment Date: _____	
<b>Blood Pressure</b>	Check one (required): <input type="checkbox"/> BP < 130/80 <input type="checkbox"/> BP ≥ 130/80	Measurement Date: _____ BP Value: _____	
<b>Cholesterol</b> (measured by total cholesterol or low-density lipoprotein)	Check one (required): <input type="checkbox"/> Total cholesterol < 200 or LDL < 130 <input type="checkbox"/> Total cholesterol ≥ 200 or LDL > 130	Measurement Date: _____ Total Cholesterol: _____mg/dl Triglycerides: _____mg/dl HDL: _____mg/dl LDL: _____mg/dl	
<b>Weight</b> (measured by body mass index)	Check one (required): <input type="checkbox"/> BMI ≤ 28 <input type="checkbox"/> BMI > 28	Measurement Date: _____ BMI: _____ Waist: _____inches Height: _____ft. _____inches Weight: _____lbs.	
<b>Blood Sugar</b> (measured by fasting blood sugar or hemoglobin A1c)	Check one (required): <input type="checkbox"/> FBS ≤ 100 or A1c ≤ 5.8 if non-diabetic or A1c < 7 if diabetic <input type="checkbox"/> FBS > 100 or A1c > 5.8 if non-diabetic or A1c ≥ 7 if diabetic	Measurement Date: _____ <input type="checkbox"/> Non-diabetic <input type="checkbox"/> Diabetic FBS: _____mg/dl OR A1c: _____%	
Member follow-up: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> as needed			
This information is confidential and your results will not be shared with your employer. The signed parties agree that all of the information supplied is complete and accurate. Make a copy of this completed form and keep for your records.			
<small>© 2019 by Blue Cross of Idaho, an independent licensee of the Blue Cross and Blue Shield Association</small>			

**Please note:** The information from your HQF is strictly confidential. Blue Cross of Idaho will not share any details with your employer, but will only inform them of your qualification status.



# Jefferson School District #251

BlueCross of Idaho PPO Effective September 1, 2020

(Non Qualified)

	<u>In Network</u>	<u>Out of Network</u>
School District Pool <b>Deductible</b>	\$1000 Ind / \$2000 family***	\$1000 Ind / \$2000 family***
School District Pool <b>Co-Insurance</b>	You Pay 20% School Pays 80%	You Pay 20% School Pays 80%

**\*\*\*Employee must submit all EOB's to GBS of Idaho to receive \$1,000 deductible benefit. Employees must also participate in Healthy Measures Wellness program, and qualify to receive \$500 deductible benefit. Other wise Individual deductible will be \$1,000 and \$2,000 Family\*\*\***

Blue Cross <b>Deductible</b>	Up to: \$3000 Ind/\$6000 Family	Up to: \$3000 Ind/\$6000 Family
BlueCross <b>Coinsurance</b>	You pay 30% Blue Cross pays 70%	You pay 50% Blue Cross pays 50%

<b>Coinsurance Out-Of-Pocket</b> (Not Including Deductible)	Up to: \$1500 In Network * Combination of both out of pockets can be reached	Up to: \$3000 Out of Network
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<b>Major Medical</b> (After Deductible and Coinsurance have been met)	100%	100%
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<b>Physician Office Visit</b>	\$30 / \$60 specialist	N/A
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<b>Prescription Drug</b>	In network pharmacy -You pay \$10 Preferred generic, or \$20 Non-Preferred Generic. Then \$250 Deductible / \$30 Preferred brand name, or \$50 Non Preferred brand name. Specialty Preferred 20%, or Specialty Non-Preferred 30%. Total Annual Out of Pocket is \$2,000	
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<b>Maternity</b>	You pay 20% after deductible	You pay 40% after deductible
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<b>Immunizations</b> (Does Not Include Office Visit)	covered 100%	covered 100%
	For covered immunizations	

<b>Inpatient Rehab.</b>	You pay 20% / 30% A.D.	Not Covered
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<b>Outpatient Speech, Physical, or Occupational Therapy</b> (20 visit combined max per insured)	You pay 20% / 30% A.D.	Not Covered
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<b>Chiropractic Care</b> (\$800 max per insured)	You pay 20% / 30% A.D.	You pay 50% A.D.
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<b>Mental Health</b> (Psychotherapy Services)	\$30 / \$60 Copay	You pay 40% A.D.
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<b>Wellness / Preventative</b>	100% up to policy limits for covered services	You pay 40% A.D.
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Preauthorization, Claims, Network Provider information 1-800-627-1006 / www.bcidaho.com  
 For buydown questions or any additional information contact GBS of Idaho 529-3541  
**Open Enrollment is August 1st to August 30th for a September 1st effective date.**  
*PLEASE SEE GROUP CONTRACT FOR FULL BENEFIT INFORMATION. Benefits can have restrictions and/or limitations. Group Contract Supersede's this summary*  
 EOB's are explanation of benefits that you receive from Blue Cross

# Jefferson School District #251

BlueCross of Idaho PPO Effective September 1, 2020

(Wellness Qualified)

	<u>In Network</u>	<u>Out of Network</u>
School District Pool <b>Deductible</b>	\$500 Ind / \$1000 family***	\$500 Ind / \$1000 family***
School District Pool <b>Co-Insurance</b>	You Pay 20% School Pays 80%	You Pay 20% School Pays 80%

**\*\*\*Employee must submit all EOB's to GBS of Idaho to receive \$500 deductible benefit. Employees must also participate in Healthy Measures Wellness program, and qualify to receive \$500 deductible benefit. Other wise Individual deductible will be \$1,000 and \$2,000 Family\*\*\***

Blue Cross <b>Deductible</b>	Up to: \$3000 Ind/\$6000 Family	Up to: \$3000 Ind/\$6000 Family
BlueCross <b>Coinsurance</b>	You pay 30% Blue Cross pays 70%	You pay 50% Blue Cross pays 50%

<b>Coinsurance Out-Of-Pocket</b> (Not Including Deductible)	Up to: \$1500 In Network * Combination of both out of pockets can be reached	Up to: \$3000 Out of Network
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<b>Major Medical</b> (After Deductible and Coinsurance have been met)	100%	100%
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<b>Physician Office Visit</b>	\$30 / \$60 specialist	N/A
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<b>Prescription Drug</b>	In network pharmacy -You pay \$10 Preferred generic, or \$20 Non-Preferred Generic. Then \$250 Deductible / \$30 Preferred brand name, or \$50 Non Preferred brand name. Specialty Preferred 20%, or Specialty Non-Preferred 30%. Total Annual Out of Pocket is \$2,000	
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<b>Maternity</b>	You pay 20% after deductible	You pay 40% after deductible
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<b>Immunizations</b> (Does Not Include Office Visit)	covered 100%	covered 100%
	For covered immunizations	

<b>Inpatient Rehab.</b>	You pay 20% / 30% A.D.	Not Covered
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<b>Outpatient Speech, Physical, or Occupational Therapy</b> (20 visit combined max per insured)	You pay 20% / 30% A.D.	Not Covered
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<b>Chiropractic Care</b> (\$800 max per insured)	You pay 20% / 30% A.D.	You pay 50% A.D.
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<b>Mental Health</b> (Psychotherapy Services)	\$30 / \$60 Copay	You pay 40% A.D.
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<b>Wellness / Preventative</b>	100% up to policy limits for covered services	You pay 40% A.D.
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Preauthorization, Claims, Network Provider information 1-800-627-1006 / [www.bcidaho.com](http://www.bcidaho.com)  
 For buydown questions or any additional information contact GBS of Idaho 529-3541  
**Open Enrollment is August 1st to August 30th for a September 1st effective date.**  
*PLEASE SEE GROUP CONTRACT FOR FULL BENEFIT INFORMATION. Benefits can have restrictions and/or limitations. Group Contract Supersede's this summary*  
 EOB's are explanation of benefits that you receive from Blue Cross

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Benefit Highlight Sheet Jefferson School District 251	HSA Blue <sup>SM</sup> PPO for Idaho School Benefit Trust	
	In-Network	Out-of-Network
<b>Effective Date</b> September 1, 2020		
<b>Benefit Period* Aggregate Deductible**</b> (Individual/Family, applies to benefits below unless noted.)	\$6,800/\$13,600	
<b>Cost Sharing</b>	No charge	No charge
<b>Out-of-Pocket Limit</b> (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)	\$6,800/\$13,600	
<b>COVERED SERVICES</b> <i>By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. This is called balance-billing. Some services may require prior authorization.</i>	In-Network	Out-of-Network
	<b>What you pay</b>	
<b>Ambulance Transportation Services</b>	Deductible	Deductible
<b>Breastfeeding Support and Supply Services</b> (Limited to one (1) breast pump purchase per benefit period, per Participant)	No charge	
<b>Chiropractic Care</b> (Limited to 18 visits combined per Participant, per benefit period)	Deductible	
<b>Dental Services Related to Accidental Injury</b>		
<b>Diabetes Self-Management Education Services</b> (Only for accredited providers approved by BCI.)		
<b>Diagnostic Services</b> (Including diagnostic mammograms)		
<b>Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances</b>		
<b>Emergency Services – Facility Services</b> (Copayment waived if admitted) (Additional services, such as laboratory, x-ray, and other Diagnostic Services are subject to applicable Deductible, Cost Sharing and/or Copayment.) (BCI will provide in-network benefits for treatment of Emergency Medical Conditions. Participant may be balance-billed for these services.)	\$100 Copayment for hospital Outpatient emergency room visit, then Deductible	\$100 Copayment for hospital Outpatient emergency room visit, then Deductible
<b>Emergency Services – Professional Services</b> (BCI will provide in-network benefits for treatment of Emergency Medical Conditions. Participant may be balance-billed for these services.)	Deductible	Deductible
<b>Home Health Skilled Nursing</b>		
<b>Home Intravenous Therapy</b>		
<b>Hospice Services</b>		
<b>Hospital Services</b> (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)		
<b>Rehabilitation or Habilitation Services</b>		
<b>Maternity Services and/or Involuntary Complications of Pregnancy</b>		
<b>Medical Services (Inpatient and outpatient)</b>		
<b>Mental Health– Inpatient and Outpatient</b> (Facility and Professional Services) (No charge after Deductible for Outpatient Psychotherapy Services, for Participants under the age of eighteen (18).)		
<b>Outpatient Applied Behavioral Analysis</b> (as part of an approved treatment plan)		

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<b>Outpatient Habilitation Therapy Services</b> (Includes physical, speech and occupational therapies. Limited to 20 visits combined per Participant, per benefit period.)	Deductible	Deductible
<b>COVERED SERVICES</b> <i>By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. This is called balance-billing. Some services may require prior authorization</i>	<b>In-Network</b>	<b>Out-of-Network</b>
	<b>What you pay</b>	
<b>Outpatient Rehabilitation Therapy Services</b> (Includes physical, speech and occupational therapies. Limited to 20 visits combined per Participant, per benefit period.)	Deductible	Deductible
<b>Pediatric Physician Office Visit</b> (For Participants under the age of eighteen (18).)	No charge after Deductible	
<b>Physician Office Visit</b>	Deductible	
<b>Prescribed Contraceptive Services</b> (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)	No charge	
<b>Post-Mastectomy/Lumpectomy Reconstructive Surgery</b>	Deductible	
<b>Skilled Nursing Facility</b> (Limited to 30 days combined per Participant, per benefit period.)		
<b>Surgical/Medical Therapy Services</b> (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)		
<b>Transplant Services</b>	No charge for services specifically listed  For services not specifically listed Deductible	
<b>Preventive Care Benefits</b> (See plan for specifically listed services)		
<b>Immunizations</b> (See Plan for specifically listed immunizations)	No charge for listed immunizations	
<b>Telehealth Services</b> (Services provided by MDLIVE for Medical Consult, Psychotherapy Treatment, Outpatient Medication Management and Psychiatric Evaluation/Medical Service covered services)	Deductible and Cost Sharing  To request a consultation, call 1-888-920-2975 or visit the website at <a href="http://www.mdlive.com/bcidaho">www.mdlive.com/bcidaho</a> [mdlive.com].	
<b>Treatment for Autism Spectrum Disorder</b> (Services identified as part of the approved treatment plan)	Covered the same as any other illness, depending on the services rendered, see appropriate Covered Services section. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.	

\*The specified period of time during which charges for covered services must be incurred in order to accumulate toward annual benefit limits, deductible amounts and out-of-pocket limits.

\*\*One family member will not accumulate more than the individual deductible or out-of-pocket maximum toward the family deductible or out-of-pocket maximum. After one family member has met the individual deductible, benefits begin for that person. After the family deductible has been met, benefits begin for all family members.

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<b>PRESCRIPTION DRUG BENEFITS</b>		
Each non Specialty Prescription Drug shall not exceed a 90-day supply at one (1) time (Prescription Drug Services apply to the In-Network Out-of-Pocket Limit.)		
<b>RETAIL OR BCI MAIL ORDER PHARMACIES</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	<b>WHAT YOU PAY</b>	
<b>Generic Prescription Drugs</b>	No charge, after Deductible	
<b>Preferred Brand Name Prescription Drugs</b>		
<b>Non-Preferred Brand Name Prescription Drugs</b>		
<b>ACA Preventive Prescription Drugs</b>	No charge for ACA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Web site, <a href="http://www.bcidaho.com">www.bcidaho.com</a> . Deductible does not apply.	
<b>Prescribed Contraceptives</b>	No charge for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Formulary on the BCI Web site, <a href="http://www.bcidaho.com">www.bcidaho.com</a> ; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	

**Note:** Certain Prescription Drugs have generic equivalents. If the Participant requests a Brand Name Drug, the Participant is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Preferred or Non-Preferred status.

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Benefit Highlight Sheet Jefferson School District 251	
Effective Date September 1, 2020	
Prescription Benefits for Idaho School Benefit Trust	
<p><i>Each non Specialty Prescription Drug shall not exceed a 90-day supply at one (1) time</i>  <i>Specialty Prescription Drugs shall not exceed a 30-day supply at one (1) time</i>  <i>(one Copayment for each 30-day supply)</i></p>	
Retail and Mail Order	What you pay
Preferred Generic Prescription Drugs	\$10 Copayment – No Deductible required
Non-Preferred Generic Prescription Drugs	\$20 Copayment – No Deductible required
<b>\$250 Deductible for Preferred Brand Name Drugs, Non-Preferred Brand Name Drugs, Preferred Specialty Drugs, Generic Specialty Drugs and Non-Preferred Specialty Drugs</b>	
Preferred Brand Name Prescription Drugs	\$30 Copayment after Deductible
Non-Preferred Brand Name Prescription Drugs	\$50 Copayment after Deductible
Preferred Specialty and Generic Specialty Prescription Drugs	20% Coinsurance after Deductible
Non-Preferred Specialty Prescription Drugs	30% Coinsurance after Deductible
ACA Preventive Prescription Drugs	No charge for ACA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Web site, <a href="http://www.bcidaho.com">www.bcidaho.com</a> . (Deductible does not apply)
Prescribed Contraceptives	No charge for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Formulary on the BCI Web site, <a href="http://www.bcidaho.com">www.bcidaho.com</a> ; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.
Out-of-Pocket Limit	<p><b>Individual:</b> \$2,000 in Copayments and/or Cost Sharing per Benefit Period for a combination of all Prescription Drug charges incurred.</p> <p><b>Family:</b> Combination of \$4,000 in Copayments and/or Cost Sharing per Benefit Period for a combination of all Prescription Drug charges incurred.</p> <p><i>When the Prescription Drug Out-of-Pocket Limit is met, the Prescription Drug Benefits payable will increase to 100% of the Allowed Charge or the Usual Charge for the remainder of the Benefit Period.</i></p>

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## *Prescription Benefits*

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Certain Prescription Drugs have generic equivalents. If the Participant requests a Brand Name Drug, the Participant is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Preferred or Non-Preferred status.

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Applies to **non-grandfathered** individual and group plans

## Highlights of your preventive care benefits:

- You pay nothing; no coinsurance, copayment or deductible, for covered preventive care services when you visit in-network providers.
- Preventive care benefits for services from out-of-network providers are subject to your out-of-network benefit.
- Updates for 2019: Colorectal Cancer Screenings was updated to remove the specifically listed procedures. Urinary Incontinence Screening was added. Preeclampsia screening was added.

Covered Preventive Care Services	In-Network	Out-of-Network
<p><b>Specifically Listed Services</b>            Annual adult physical examinations; Routine or scheduled well-baby and well-child examinations, including vision, hearing and developmental screenings; Dental fluoride application for participants age 5 and younger; Bone density; Chemistry panels; Cholesterol screening; Colorectal cancer screening; Complete Blood Count (CBC); Diabetes screening; Pap test; PSA test; Rubella screening; Screening EKG; Screening mammogram; Thyroid Stimulating Hormone (TSH); Transmittable diseases screening (Chlamydia, Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV), Syphilis, Tuberculosis (TB)); Hepatitis B virus screening; Sexually transmitted infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Urinary Incontinence Screening; Aortic aneurysm ultrasound; Alcohol misuse assessment; Breast cancer (BRCA) risk assessment and genetic counseling and testing for high-risk family history of breast or ovarian cancer; Newborn metabolic screening (PKU, Thyroxine, Sickle Cell); Health risk assessment for depression; Newborn hearing test; Lipid disorder screening; Smoking cessation counseling visit; Dietary counseling (limited to three visits per participant, per benefit period); Behavioral counseling for participants who are overweight or obese; Preventive lead screening; Lung cancer screening for participants age 55 and older; Hepatitis C virus infection screening.</p> <p>For Groups who offer maternity coverage to enrollees and enrolled eligible dependent spouses: Gestational diabetes screening for pregnant women; Iron deficiency screening for pregnant women; Rh (D) incompatibility screening for pregnant women; and Urine culture for pregnant women; preeclampsia screening.</p>	<p>You pay nothing of the allowed amount for specifically listed preventive care services per person, per benefit period.</p> <p>No copayment, deductible or coinsurance required.</p>	<p>You pay costs subject to your out-of-network benefit.</p>
<p><b>Women’s Preventive Health Services</b>            (Applies to group and individual plan members unless otherwise noted.)</p>	<p><b>In-Network</b></p>	<p><b>Out-of-Network</b></p>
<p>Well Woman visits (for recommended age-appropriate preventive services); breastfeeding support, supplies and counseling.</p>	<p>You pay nothing of the allowed amount for specifically listed preventive care services per person, per benefit period.</p>	<p>You pay costs subject to your out-of-network benefit.</p>
<p>For Groups that offer Prescribed Contraceptive Coverage: Blue Cross of Idaho pays 100 percent for women’s preventive prescription drugs and devices as specifically listed on the Blue Cross of Idaho website, <a href="http://bcidaho.com">bcidaho.com</a>; deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one time, as applicable to the specific contraceptive drug or supply.</p>	<p>No copayment, deductible or coinsurance required.</p>	<p>You pay costs subject to your out-of-network benefit.</p>
<p><b>Prescribed Contraceptive Services</b>            Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation</p>	<p>No copayment, deductible or coinsurance required.</p>	<p>You pay costs subject to your out-of-network benefit.</p>



Immunizations	In-Network	Out-of-Network
<p>Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox), Hepatitis A, Meningococcal, Human Papillomavirus (HPV) and Zoster.</p> <p>All Immunizations are limited to the extent recommended by the Advisory Committee on Immunization Practices (ACIP) and may be adjusted accordingly to coincide with federal government changes, updates and revisions.</p>	<p>You pay nothing for specifically listed immunizations.</p> <p>No copayment, deductible or coinsurance required.</p>	
<p>Other immunizations not specifically listed may be covered when Medically Necessary and approved by the Blue Cross of Idaho Pharmacy and Therapeutics Committee.</p>	<p>You pay costs subject to your in-network benefit.</p>	<p>You pay costs subject to your out-of-network benefit.</p>

**Please Note:** Your provider must bill these services as preventive/wellness services.

The specifically listed preventive care services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.

**The descriptions above are general in nature, to allow for an overall view of Blue Cross of Idaho’s preventive care coverage.**

**For complete descriptions of your policy and policy changes, please read your contract and contract amendment language.**

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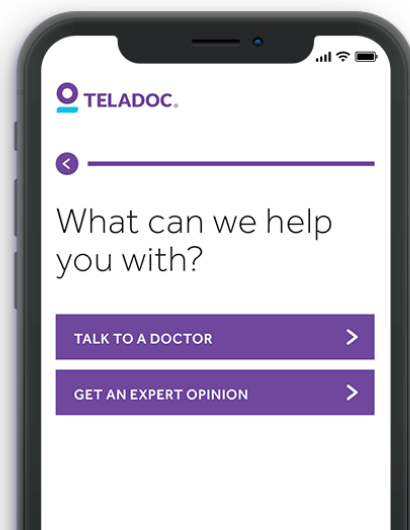
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## Preferred Blue® Dental PPO

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### Benefit Highlight Sheet Jefferson School District 251 Effective Date September 1, 2020

Preferred Blue® Dental PPO Plan for Idaho School Benefit Trust	In-Network	Out-of-Network.
<b>Individual/Family Deductible</b> (Deductible applies to In-Network basic, major services, and all Out-of-network services. The Family Deductible is satisfied after three (3) Participants of the same family have met their Individual Deductible.)	\$50/3 Family Maximum	
<b>Individual Benefit Period Maximum</b>	\$1,250	
<b>Preventive Services</b>	<b>What you pay</b>	
<b>Oral Examinations</b> One (1) examination every six (6) months.	No charge of the allowed amount	By choosing an Out-of-Network provider 20% of the allowed amount*
<b>Fluoride</b> Limited to one (1) application per benefit period and limited to Participant's who are under age twenty-six (26).		
<b>Sealants:</b> Limited to permanent posterior unrestored dentition of eligible dependent children under age sixteen (16) and limited to one (1) time per tooth in any three (3) consecutive benefit periods.		
<b>X-rays, Bitewings</b> Once per benefit period.		
<b>X-rays, Complete Mouth Series or Panoramic x-ray</b> One (1) time in any five (5) consecutive benefit periods.		
<b>Prophylaxis (Cleaning)</b> Once every six (6) months. (Regardless of type)		
<b>Basic Services</b>	<b>What you pay</b>	
<b>Filings</b> Restorations involving multiple surfaces will be combined and paid according to the number of surfaces treated; same tooth surface restoration is covered once in two (2) year period.	20% of the allowed amount	By choosing an Out-of-Network provider 30% of the allowed amount*
<b>Extractions</b>		
<b>Root Canal Therapy</b>		
<b>Periodontal Maintenance</b> Once every six (6) months. (Regardless of type)		
<b>Scaling and Root planing</b> Once per quadrant of the mouth every three (3) benefit periods.		
<b>Occlusal Guard</b> One appliance every two (2) benefit periods.		
<b>Osseous Surgery</b> Once per area of the mouth every three (3) years.		
<b>Space Maintainers</b> Limited to Participant's who are under age sixteen (16). Benefits limited to deciduous teeth. Includes all adjustments made within six (6) months of installation.		

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ISBT 2020 PPO No Ortho Dental HLS



## Preferred Blue® Dental PPO

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<b>Major Services</b> Preauthorization required on all major services	<b>What you pay</b>	
<b>Bridges, Inlays, Onlays, Crowns, Veneers, and Full or Partial Dentures</b> Five (5) year replacement.	50% of the allowed amount	By choosing an Out-of-Network provider 50% of the allowed amount*
<b>Dental Implants</b> Including the implant body, implant abutment and implant crown – benefits may be available up to the Maximum Allowance of a standard complete or partial denture, or bridge. Implant body and abutment-limited to once per tooth per lifetime. Implant crown –five (5) year replacement.		

**\*By choosing an Out-of-Network provider you pay your cost sharing, deductible, and any difference between what Blue Cross of Idaho allows and what the Out-of-Network provider charges.**

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ISBT 2020 PPO No Ortho Dental HLS



## Dental Blue Connect Plan for Idaho School Benefit Trust

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Benefit Highlight Sheet Jefferson School District 251 Effective Date September 1, 2020	Dental Blue Connect Plan 3 for Idaho School Benefit Trust
	<b>Contracting Providers*</b>
	What You Pay
<b>Individual Deductible</b>	No Deductible
<b>Annual Maximum</b>	No Annual Maximum
<b>General Office Visit</b>	\$25 Copayment per visit
<b>Diagnostic and Preventive Services</b>	
<b>Routine and Emergency Exams</b>	No charge after applicable Office Visit Copayment
<b>All X-rays</b>	
<b>Teeth Cleaning</b>	
<b>Fluoride Treatment</b>	
<b>Sealants</b>	
<b>Head and Neck Cancer Screening</b>	
<b>Oral Hygiene Instruction</b>	
<b>Periodontal Charting</b>	
<b>Periodontal Evaluation</b>	
<b>Restorative Dentistry</b>	
<b>Filings</b>	\$25 Copayment per visit
<b>Stainless Steel Crown</b>	\$300 Copayment per visit.
<b>Porcelain-Metal Crown</b>	
<b>Prosthetics</b>	
<b>Complete Upper or Lower Denture</b>	\$400 Copayment per visit
<b>Bridge (per Tooth)</b>	\$300 Copayment per visit
<b>Endodontics and Periodontics</b>	
<b>Root Canal Therapy — Anterior</b>	\$125 Copayment per visit
<b>Root Canal Therapy — Bicuspid</b>	\$175 Copayment per visit
<b>Root Canal Therapy — Molar</b>	\$200 Copayment per visit
<b>Osseous Surgery (per Quadrant)</b>	\$250 Copayment per visit
<b>Root Planing (per Quadrant)</b>	\$100 Copayment per visit
<b>Oral Surgery</b>	
<b>Routine Extraction (Single Tooth)</b>	\$25 Copayment per visit
<b>Surgical Extraction</b>	\$150 Copayment per visit
<b>Orthodontic Services</b>	
<b>Pre-Orthodontic Service</b> (Fee credited toward the Comprehensive Orthodontic Service copayment if patient accepts treatment plan)	\$150 Copayment per visit
<b>Comprehensive Orthodontic Service</b>	\$2,500 Copayment per visit
<b>Miscellaneous</b>	
<b>Local Anesthesia</b>	No charge after applicable Office Visit Copayment
<b>Dental Lab Fees</b>	
<b>Nitrous Oxide</b>	\$20 Copayment per visit
<b>Specialty Office Visit</b>	\$30 Copayment per visit
<b>Emergency Office Visit</b>	\$25 Copayment per visit
<b>Implants</b>	No charge up to \$1,500
<b>Out of Area Emergency Care Reimbursement up to \$250</b>	

**Supported by Willamette Dental Group – 1.855.4DENTAL (1-855-433-6825)**

The information in this Highlight Sheet is for informational and comparison purposes only. It is not a complete summary or description of benefits Coverage is subject to the provisions of the corresponding Plan Documents and Summary Plan Description, which contains the detailed terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the Plan Document and Summary Plan Description issued for a more complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference or conflict between this Highlight Sheet and its corresponding Plan Documents and Summary Plan Description, the Plan Documents and Summary Plan Description will control. This Highlight Sheet is subject to annual update.

**DISCLAIMER: PRELIMINARY DRAFT – FOR GENERAL INFORMATION PURPOSES ONLY.** This Highlight Sheet is pending regulatory approval and is subject to change (which may be significant or material). The information and terms contained herein may not be relied upon for any reason and neither this Highlight Sheet nor any of the information or terms contained herein shall form the basis of any contract or commitment by any party. No representation or warranty, express or implied, is provided in relation to the accuracy, correctness, completeness or reliability of the information and terms contained herein. The final version of this Highlight Sheet will be furnished to interested parties following regulatory approval. Additional terms and conditions may apply.

<b>Benefit Highlight Sheet [Jefferson School District 251 Effective Date September 1, 2020</b>	
<b>VISION CARE BENEFITS (VCSV) for Idaho School Benefit Trust – Option I</b>	
<b>For Covered Providers and Services</b>	<b>What you pay</b>
<b>Copayment</b>	\$25 per eye exam and/or \$25 per Frame and Lenses or Medically Necessary Contact Lenses.
<b>Service Frequency Limitations</b>	
<b>Elective</b> —includes basic eye exam and an allowance of \$130 in place of benefits for Prescribed Lenses and Frames	You may receive one (1) eye exam and/or one (1) pair of Lenses and/or one (1) Frame or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) every twelve (12) months.
<b>Payment for Services Rendered</b>	
<b>Participating Provider</b>	BCI pays 100% of Maximum Allowance after Copayment
<b>Nonparticipating Provider</b>	
<b>Professional Fees</b>	
Eye Exam	\$45
<b>Materials—lenses per pair</b>	
Single Vision	\$45
Bifocals, up to	\$65
Trifocals, up to	\$85
Frame, up to	\$47
<b>Contact Lenses— per pair</b> (evaluation, materials, and fittings only)	\$105
<b>Medically Necessary, up to</b>	\$210

\*The Participating Provider is responsible for verifying benefits with the VCSV prior to rendering services. A Participant must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under the plan.

The information in this Highlight Sheet is for informational and comparison purposes only. It is not a complete summary or description of benefits Coverage is subject to the provisions of the corresponding Plan Documents and Summary Plan Description, which contains the detailed terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the Plan Document and Summary Plan Description issued for a more complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference or conflict between this Highlight Sheet and its corresponding Plan Documents and Summary Plan Description, the Plan Documents and Summary Plan Description will control. This Highlight Sheet is subject to annual.



## HEALTH AND WELLNESS COACHING

While you don't have to take part in health coaching, we hope you'll make use of this free, valued service. Whether you have a lifestyle issue you'd like to change or want to set up a training schedule for your first marathon, a Blue Cross of Idaho health coach can help.

Losing as few as 10 pounds and making small changes like eating more fruits and vegetables and drinking more water can improve your health in a big way.

Blue Cross of Idaho coaches can help you make those lifestyle changes so that you can be happier and healthier.

## CONTACT A HEALTH COACH TODAY!

Blue Cross of Idaho's certified health coaches and registered dietitians support you with tips, information and encouragement as you work toward your goals. Our coaches have a range of education and training, but all are well-versed in tobacco cessation, physical fitness, nutrition and stress management. We encourage you to use their vast knowledge to help improve your and your family's health and well-being.

Take the time and invest in your good health. To learn more, contact a coach at 855-216-6844. You can also email them in the wellness portal.

### Here's what Jefferson School District employees had to say about their experience with health coaching:

"I appreciate all the help you've given me to support a healthy diet. I feel great and have been loving the smoothies, thank you for that idea. I'm getting more veggies, fruit and protein because of them and have more energy too."

"I met my exercise goal for the past two weeks! Thank you for keeping me accountable. I could not have done this without your support and positivity."

## FREQUENTLY ASKED QUESTIONS

### Do I no longer need to submit an HQF?

That depends on how your doctor bills your visit. If it is billed as a preventive exam, you will get credit. If it is not billed as a preventive exam, then you must submit an HQF to get credit. Sometimes the visit may be billed differently if you discuss other illness or disease during your preventive exam.

### How will I know if I qualify for the deductible buy down?

After you submit your HQF, Blue Cross of Idaho will send you a letter in the mail to let you know your qualification status. It typically takes 10 business days. You can also check your status online in the wellness portal. If your HQF is incomplete, you will get a letter to let you know what is missing. You can fill out and resubmit the form or simply call the Customer Service Department with the missing information.

### Can I qualify for the incentive if I am overweight, diabetic or have high blood pressure?

Yes. If you do not meet the recommended targets for a health measure on the HQF, simply work with your healthcare provider to identify a treatment plan suitable for you.

### What if I don't participate?

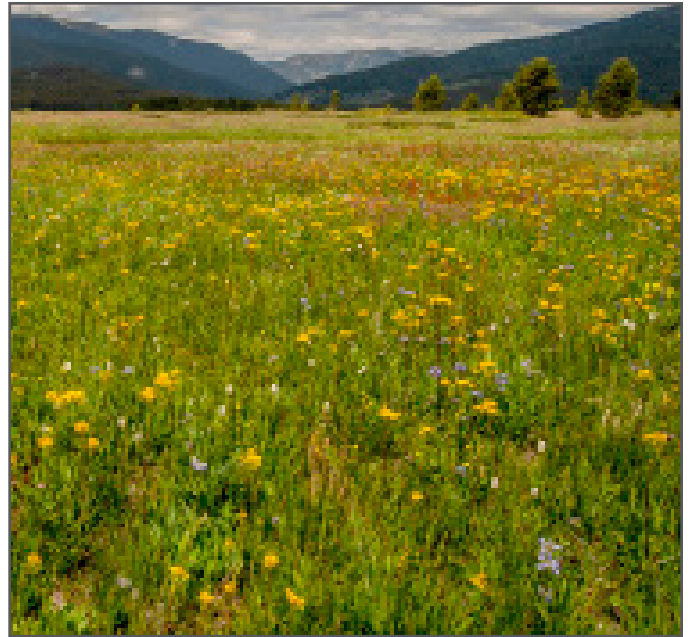
You will have a \$1,000 deductible beginning January 1, 2021.

### Will Jefferson School District see the results of my HQF?

No. All information on your HQF is private and is not shared with your employer.

### Do other family members have to participate?

No. Only employees must submit the HQF.



### Can I qualify for the incentive any time during the benefit year?

You have until November 30, 2020, to complete and submit the HQF. Late submissions can be approved through an appeal to your HR Department.

### If I've been to my doctor for a preventive visit recently, do I have to go again?

This depends on your doctor. Take the HQF to your doctor's office and ask if the doctor will fill out the form for you with the information on file. The doctor may ask that you be seen again or that blood work is drawn again to fill out the form. If the visit is billed as a preventive care visit, it will be covered at 100% as long as you are seeing an in-network provider, even if you've been seen for a preventive care visit within the past year.

### How do I get more information?

To learn more, or if you have questions about the program or your qualification status, please call Blue Cross of Idaho's Customer Service Department at 800-627-1188.

HEALTHY  
MEASURES<sup>SM</sup>  
A healthier you starts here

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanese, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：1-800-377-1363)。

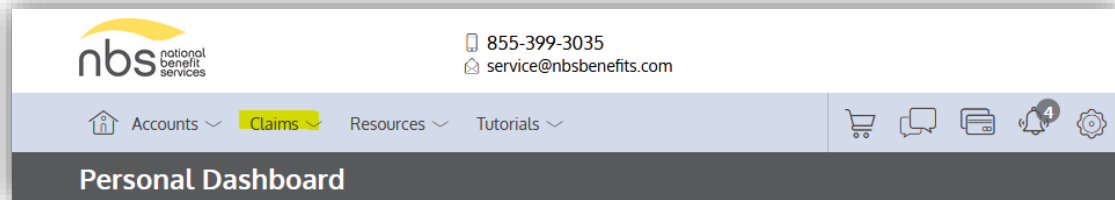
Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).



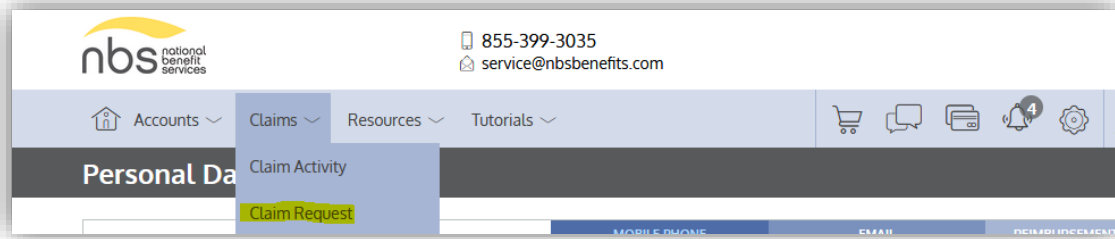
## Filing claims online through your Participant Portal:

Login to the National Benefits Participant Portal, <https://mynbsbenefits.com/>. For information on how to login/register for the Participant Portal please see the “Creating your Flexible Benefit Plan Account” document.

From the main page select **Claims**



Then from the dropdown option, select **Claim Request**



You should now see the following screen:

**Add claim for immediate reimbursement**

CLAIM DETAILS DOCUMENTATION CONFIRM SUBMISSION

**Claim Form Instructions**

**Please note the following special instructions:**

You must provide documentation to substantiate your claim. Credit card receipts do not contain the sufficient documentation necessary for a reimbursement. Your documentation must provide: the date of service, the amount paid, and a description of the service provided.

If you select a Provider below you are agreeing to pay that provider directly. **Do not select this option unless you want reimbursement sent to your provider.**

If you are submitting to the HRA, be sure to select HRA under the "Service Type" option and attach an Explanation of Benefits (EOB).

If you are submitting to the Dependent Care Assistance Plan (DCAP), the receipt must also include the provider's SSN or Tax ID number and a date range for the service provided.

\* - Required Field

Service Type \* -- Select One --




Service Start Date \* select date

When you are ready to submit a claim, you will start here and enter:

1. Service Type



At this point you will need to select the correct Service Type depending on the type of service/item received.




\* - Required Field

 Service Type *	<input type="text" value="FSA Medical"/>
 Service Start Date *	<input type="text" value="-- Select One --"/>
 Service End Date	<input type="text" value="FSA Medical"/>
	<input type="text" value="FSA Rx"/>
	<input type="text" value="FSA Vision"/>

Next you will select


2. Service Start Date and Service End Date
3. Claimant (person who received services)
4. Select how you would like to be reimbursed (Check or Direct Deposit)

 Service Start Date *	<input type="text" value="select date"/>
 Service End Date	<input type="text" value="select date"/>

 Claimant	<input type="text" value=""/>
 Reimbursement Method *	<input type="text" value="Direct Deposit"/>
 Claim Amount *	<input type="text" value="\$ 0.00"/>

Finally, you will want to enter the amount you are claiming for reimbursement. Then, you will select if the payment should go to you or to the provider of services.


At this point, if your provider has not been paid, you can also select to have the payment for the amount listed in the deductible column go directly to the provider by selecting the “Pay Provider” option. **If you would like payment to come directly to you, DO NOT select the “Pay Provider” option.**


 Whom shall we pay?\*

Pay Provider  Pay Me

If you select the “Pay Provider” option, you will then be prompted to add the Provider name and address, as well as Tax ID Number, if you have it. *(You can still select this option even if you don't have the provider Tax ID Number)*


If you select the “Pay me” option, you simply enter the provider name in the Provider Name field as well as an account number, if you have it. *(The account number is not a required field)*


 Provider Name

 Account Number

There is a comments section if you feel any special comments regarding the submission are necessary, but they are not required for submission. You can now hit “next” to be taken to the page to attach a digital copy of your Itemized Billing, EOB or Rx detail receipt.

CLAIM DETAILS > DOCUMENTATION > CONFIRM SUBMISSION

 Please Choose a Validation Method to Continue

 **Attach Claim Receipt**  
Take a photo of your receipt or attach an existing document now.

Once you select this option, you will be taken to the screen below, which will allow you to either “drag & drop” your claim documentation into the submittal field, or you can select the “browse” option to find the EOB on your computer in its saved location.

**Add claim for immediate reimbursement - Add Receipt**

Upload Receipt  **BROWSE**

**DRAG & DROP**  
your receipts here

After you have added your claim documentation, you will select the “Next” button. You will then be taken to the final submission and confirmation screen. At the top, you will see your claim details.

CLAIM DETAILS DOCUMENTATION CONFIRM SUBMISSION

Claim Details

Amount:	\$75.00
Type:	Check
Claimant:	[REDACTED]
Service Type:	FSA Medical
Service Start Date:	Jun 3, 2020
Service End Date:	Jun 3, 2020
Comments:	
Provider:	Davis MD

Below that you will see the following box. You will need to check the “I understand” box and then select the “Submit” button at the bottom.

I understand and agree to the following:

- 1) The expenses listed above have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
- 2) The expenses must qualify for reimbursement under the Internal Revenue Code. To qualify, documentation must include date of service, amount paid, and a description of the service provided.
- 3) I have retained copies of the documentation submitted with this request as these materials will not be returned to me.
- 4) The expenses listed above were incurred by myself and/or my eligible dependents as defined by the IRS.
- 5) It is the Employee's responsibility to ensure all claims have been uploaded properly and received at NBS.
- 6) For HRA claims, an Explanation of Benefits (EOB) must be submitted as supporting documentation.

Once you hit the "Submit" button, you will receive the following message and options. Please note, you can click the "Submit Another Claim" button for each new deductible expense date and amount on your EOB's for which you are seeking reimbursement.

Please remember to Submit claims individually for each family member and for each provider of services and service date.

Thank you!

Once your claim has been reviewed by one of our claims processors, it will appear under Pending Claims where you can verify the status of your reimbursement

---

What do you want to do next?

- 
- 
-

First Time Login

# NBS Web Portal

## How Do I Access My Online Account?

Registering for and logging into your account online is easy. Just follow the instructions below.

### 1 Get to the website

- ▶ Using your Internet browser, navigate to: <http://my.nbsbenefits.com>
- ▶ Click "Register" on the home page. (Highlighted in red below.)

The screenshot shows the NBS Web Portal home page. At the top left is the NBS logo (national benefit services) and contact information: 855-399-3035 and service@nbsbenefits.com. On the top right, there are two buttons: "SIGN IN" (with a checkmark icon) and "REGISTER" (with a person icon and highlighted in red). Below the buttons, a message reads: "Welcome to our new portal. To use the legacy portal, click here. The legacy portal will be retired on October 28th." To the right of this message is a note: "If you have an existing username and password, click 'Sign In' - there is no need to register again. If you have never registered, click 'Register.'" The main content area features a large photo of a smiling family (mother, daughter, father, and son) with blue arrows on either side. Below the photo is a "QuickLinks" section with six icons and text: "Which Plan is Right for Me?", "Documents & Forms", "Frequently Asked Questions", "Short Term Savings", "Calculate your Tax Savings", and "Enroll Here". To the right of the QuickLinks is a section for the mobile app, showing a smartphone and tablet displaying the app interface, with the text "TRY OUR MOBILE APP" and logos for Google Play and the App Store.

## 2 Complete the required fields of the registration form

- ▶ Username and password
- ▶ Personal information - name and email address
- ▶ Employee ID: Please enter your **Social Security Number**
- ▶ Employer ID OR NBS Benefits Card Number.
  - Employer ID is a 9 digit code given to you in your welcome email from NBS, or may be obtained through your employer or by contacting NBS at (855) 399-3035
- ▶ Accept the Terms of Use
- ▶ After completing all required fields, click "Register"

### Registration

STEP 1 STEP 2 STEP 3 STEP 4

Username \*

Password \*

Password Strength

Confirm Password \*

First Name \*

Initial

Last Name \*

Email \*

Registration ID \*

Employee ID \*

I accept [Terms of Use](#)

Username must be between 6 and 12 characters long alphanumeric value

A valid password must contain between 8 and 16 characters.

A password must contain 3 of the following types of characters:

- AN UPPER CASE LETTER
- lower case letter
- Special Character (% , ! , @ , etc.)
- A number

A password cannot contain:

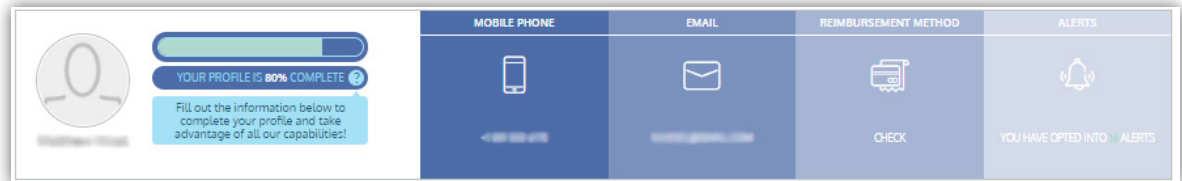
- The same character repeating 3 or more times
- The word "password"
- The username
- Spaces

To register with this site, you must have an **Employee ID** which could be your Health Plan Member Number, Social Security Number, an ID provided by your Employer or an alternate ID created by your Administrator, and a **Registration ID** which could be your Benefit Debit Card Number or your Employer.

If you do not know your ID or were not provided an ID, please contact your Administrator.

### 3 Set up direct deposit for quick and secure reimbursements.

- ▶ Select “Reimbursement Method” from the Personal Dashboard and choose “direct deposit.”



- ▶ Enter required fields including account and routing number.
- ▶ Click the checkbox agreeing for NBS to deposit funds to your account.
- ▶ Click on “Save.”

A screenshot of the 'Reimbursement Method' form. At the top, there are two tabs: 'Check' and 'Direct Deposit', with 'Direct Deposit' being the active tab. Below the tabs, there are several input fields: 'Bank Name \*', 'Account \*', 'Re-enter Account \*', 'Account Routing \*', 'Re-enter Routing \*', and 'Bank Account Type' (a dropdown menu currently set to 'Saving'). To the right of these fields is a 'Check example' section with a form for Name, Address, Date, and Pay to the order of. Below that is a 'Your bank' section with a routing number '1 233 21 1231', a check number '234511', and an account number '123456789123'. At the bottom left, there is a checkbox with an asterisk and the text: 'By providing my bank account and routing numbers, I agree to allow my administrator to direct deposit plan reimbursements into my accounts. I understand that I can change this directive at any time.' At the bottom right, there are 'Save' and 'Cancel' buttons.





# HRA Claim Form Instructions

## What is the recommended method to submit my claims?

- **Submit Claims Online:** To submit claims online, visit [mynbsbenefits.com](http://mynbsbenefits.com). Select **Claims** tab, choose **Claim Request**, fill out required fields, attach receipts, mark certification box, and click **Submit**.
- **Submit Claims using Mobile App:** Sign in, choose submit claim from main menu, enter requested info, and add a receipt by using the camera on your mobile device.
- Additional methods to submit claims manually are noted at the bottom of your claim form.

## How do I avoid delays processing my claim?

- Submit receipts either online or using the NBS mobile app for quicker reimbursement:
  - **Register to use our online website:** Manage all aspects of your account easily online. For instructions to register online, email our service center at [service@nbsbenefits.com](mailto:service@nbsbenefits.com) for assistance.
  - **Download the free NBS mobile app on your Android or IOS device:** Manage your account and upload receipts using the camera feature.
- **Direct Deposit:** Sign up for direct deposit and receive money directly to your banking account the next business day following processing completion. Visit [mynbsbenefits.com](http://mynbsbenefits.com), click user name in the top right corner, choose edit link directly above **reimbursement method**, select **direct deposit**, and fill out necessary banking information.
- **Complete a continual reimbursement form.** Avoid the hassle of submitting claims and receipts each month by submitting a continual reimbursement form for your orthodontia claims. Receive your money automatically as funds are received from your employer. Remember to save your receipts to submit at the end of the plan year. Visit [mynbsbenefits.com](http://mynbsbenefits.com) and print out a form using the resource tab.
- When submitting a paper claim:
  - Complete section 1 and 2 of claim form and indicate if there is an address change.
  - Enclose receipts in same order as services listed on claim form.
  - **Sign and date claim form.** NBS is unable to complete processing without a signature.

**\*\*Please note, due to the customizable nature of HRA plans, not all items/services suggested on this instruction page may be eligible. To avoid denial of your claim(s), please review what items/services are eligible under your plan before submitting claims for reimbursement.**

## What information is required on all receipts by the IRS?

- HRA claims require an Explanation of Benefits (EOB) to complete processing
- Name of service provider or merchant name
- Date service was performed or items purchased (*Billing/statement dates and services for future dates are not eligible*)
- Description of service (*Credit card receipts are insufficient unless "co-pay," "office visit," or "InstaCare," is indicated on the receipt.*)
- Amount of service/item
- Drug name and/or prescription number (*if applicable*)
- Orthodontic services will require an orthodontic contract or financial agreement from the provider

**\*Insufficient information on receipts provided may delay the processing of your claim(s). Please allow 24-48 hours for claims in good order to be processed.**

**Customer Service Center** – Do you have additional questions? Please contact our customer service center by emailing [service@nbsbenefits.com](mailto:service@nbsbenefits.com) or call (855) 399-3035, and we would be happy to assist you.

# HRA Claim Form



## Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must include a date, description, and amount of the service
- Please list one expense per line
- Please print in blue or black ink when using this form
- Please allow 2 business days for claims to be processed

For Account Balance:  
Go to [my.nbsbenefits.com](http://my.nbsbenefits.com)  
or call (855) 399-3035

## 1 Personal Information

Employee Name (First Name, Last Name) \_\_\_\_\_ Company Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  No  Yes  
Address Change?

Phone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

## 2 HRA Claims

	Date of Service			Provider	Service Rendered	Person Receiving Service	Amount
	MM	DD	YY				
1	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____	_____
7	_____	_____	_____	_____	_____	_____	_____
8	_____	_____	_____	_____	_____	_____	_____
9	_____	_____	_____	_____	_____	_____	_____
<b>Total Health Care Expense</b>							_____

## 3 Eligible Expenses

Please see your current SPD for a summary of your benefit

## 4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



## Voluntary Life and AD&D

### For Jefferson County School District

#### How the Plan Works

Life is full of many twists and turns. LifeMap Voluntary Life and AD&D coverage protects your family's future, no matter what life may throw your way.

- Eligibility Requirement**  
 If you are a full-time active employee working a minimum of 20 hours per week, you will be eligible for these benefits.
- Who pays for the coverage?**  
 Voluntary Life and AD&D Insurance premiums are paid by you, the employee, through payroll deduction.
- Dependent Eligibility Requirement**  
 Dependents must be a Legal Spouse and/or child(ren) up to age 26 of the covered employee to be eligible for coverage.
- Guarantee Issue**  
 Enroll within 31 days of your initial eligibility date and with no questions asked, you will be covered for up to \$100,000 in Life and AD&D Insurance. With a few extra steps of completing our Evidence of Insurability requirements, you may be covered for up to \$500,000!

**LifeMapCo.com**  
**1 (800) 794-5390**

#### Benefits Summary

##### Plan Benefits

Employee Life and AD&D Insurance	\$5,000 increments from \$20,000 to a maximum of \$500,000 or 5 times your annual earnings, whichever is less
Spouse Life and AD&D Insurance	\$5,000 increments to a maximum of \$250,000, not to exceed 50% of Employee's elected amount.
Child(ren) Life and AD&D Insurance	\$5,000 or \$10,000 (employee or spouse must elect coverage for themselves to elect Child(ren) coverage)

##### Guarantee Issue Amount

Employee	\$100,000
Child(ren)	\$10,000

##### Plan Features

Accelerated Benefit	A covered employee or spouse who is diagnosed as terminally ill may receive a portion of the life insurance benefit before death. Remaining benefits are reserved for the member's beneficiary.
Voluntary Life Only - Conversion	Voluntary Life may be converted to an individual policy, without proof of insurability, within 31 days of loss of eligibility.
Voluntary Life Only - Portability	Voluntary Life may be ported without proof of insurability within 31 days of termination. If elected, portability coverage will end the earliest of when you reach age 65 or when this master policy terminates.
Voluntary Life Only - Waiver of Premium	Voluntary Life coverage may be continued without payment of premium if a covered employee or spouse becomes totally disabled (proof of disability required). Coverage may be continued up to age 65.

##### Reduction Schedule

If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce to 65% at age 65, to 40% at age 70, and to 25% at age 75.

##### Accidental Death & Dismemberment

If due to an accident you die, lose a limb, sight of an eye or become paralyzed, benefits are available.

##### AD&D Benefits Included

- Adaptive Home/Vehicle Benefit
- Rehab Benefit
- Air Bag and Seat Belt
- Spouse and Child Education
- Coma
- Day Care
- Exposure and Disappearance
- Felonious Assault

*This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this summary and the master policy, master policy provisions will prevail.*

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## Basic Life and AD&D Insurance

For Jefferson County School District - Actives

### How the Plan Works

Life is full of many twists and turns. LifeMap Basic Life and AD&D coverage protects your family's future, no matter what life may throw your way.

- Eligibility Requirement**  
 If you are a full-time active employee working a minimum of 20 hours per week, you will be covered with these benefits.
- Who pays for the coverage?**  
 Life and AD&D Insurance premiums are paid for by your employer. Dependent Life insurance premiums are paid for by you.
- Dependent Eligibility Requirement**  
 Dependents must be a Legal Spouse, and/or child(ren) up to age 26 of the covered employee to be eligible for coverage.
- Guarantee Issue**  
 With no questions asked, you will be covered for up to \$50,000 in Basic Life and AD&D Insurance.

LifeMapCo.com  
1 (800) 794-5390

### Benefits Summary

#### Plan Benefits

Employee Life Insurance	\$50,000
Employee AD&D Insurance	\$50,000
Dependent Life Insurance	Spouse \$10,000 Child(ren): \$5,000

#### Guarantee Issue Amount

Employee	\$50,000
Spouse	\$10,000
Dependent Child(ren)	\$5,000

#### Plan Features

Accelerated Benefit	A covered employee who is diagnosed as terminally ill may receive a portion of the life insurance benefit before death. Remaining benefits are reserved for the member's beneficiary.
Conversion	Option of converting to an individual life policy, without proof of insurability, within 31 days of termination.
Portability	You may elect to port your Voluntary Life insurance to continue your coverage under the group policy. If elected, portability coverage will end the earliest of when you reach age 65 or when this master policy terminates.
Waiver of Premium	Life coverage continued without payment of premium if insured becomes totally disabled (proof of disability required). Coverage may be continued up to age 65.

#### Reduction Schedule

If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce to 65% at age 65, to 40% at age 70, and to 25% at age 75.

#### Accidental Death & Dismemberment

If due to an accident you die, lose a limb, sight of an eye or become paralyzed, benefits are available.

#### AD&D Benefits Included

- Adaptive Home/Vehicle Benefit
- Rehab Benefit
- Air Bag and Seat Belt
- Spouse and Child Education
- Coma
- Day Care
- Exposure and Disappearance
- Felonious Assault

This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this summary and the master policy, master policy provisions will prevail.



Insurance for every step of life.

### Additional Benefits

- **Travel Assistance**  
When traveling 100 or more miles away from home, or outside of your home country, you can obtain emergency medical, travel, and personal security assistance 24 hours a day, anywhere in the world.
- **Repatriation**  
If death occurs more than 100 miles from your primary residence, a benefit may be payable to prepare and ship your body to the place of burial or cremation.
- **Seat Belt**  
If you die in an automobile accident and were wearing your seat belt, your beneficiary(ies) will collect an amount equal to the AD&D benefit to a maximum of \$50,000 in addition to the Basic Life and Basic AD&D benefits described above.

### Limitations & Exclusions

- **Life:** No restrictions or exclusions regarding time, place or circumstances of death.
- **AD&D** benefits are not payable for death or dismemberment caused by or as result of:
  - suicide or such attempts;
  - participation in a riot;
  - war or act of war;
  - military service for any country;
  - committing or attempting to commit an assault or felony;
  - sickness, disease or pregnancy or any medical treatment for sickness, disease or pregnancy;
  - heart attack or stroke;
  - bodily infirmity or disease from bacterial or viral infections not the result of an injury; or
  - taking medications, drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed and used/consumed in accordance with the directions of the prescribing physician or administered by a licensed physician.
  - travel, flight in or descent from any aircraft, including balloons and gliders, except as a fare-paying passenger on a regularly scheduled flight;
  - the insured Employee's intoxication

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### Monthly Rates

Life Rate per \$1,000 of Benefit	
Age	Employee & Spouse
29 and under	\$0.05
30-34	\$0.08
35-39	\$0.09
40-44	\$0.10
45-49	\$0.17
50-54	\$0.26
55-59	\$0.43
60-64	\$0.66
65-69	\$1.27
70 and over	\$2.64
Dependent Child Life Rate per \$1,000 of Benefit	
\$0.12	
regardless of the number of children in the family	
Employee AD&D Rate per \$1,000 of Benefit	
\$0.025	

### Limitations & Exclusions

- **Life:** Suicide, intentionally self-inflicted injury; or any attempts to injure oneself are excluded during the first two years of coverage or increase of coverage.
- **AD&D** benefits are not payable for death or dismemberment caused by or as result of:
  - suicide or such attempts;
  - participation in a riot;
  - war or act of war;
  - military service for any country;
  - committing or attempting to commit an assault or felony;
  - sickness, disease or pregnancy or any medical treatment for sickness, disease or pregnancy;
  - heart attack or stroke;
  - bodily infirmity or disease from bacterial or viral infections not the result of an injury; or
  - taking medications, drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed and used/consumed in accordance with the directions of the prescribing physician or administered by a licensed physician.
  - travel, flight in or descent from any aircraft, including balloons and gliders, except as a fare-paying passenger on a regularly scheduled flight;
  - the insured person's intoxication

### Monthly Premium Calculation

To calculate your monthly payroll deduction, use the formula below:

$$\begin{array}{c}
 \boxed{\phantom{00000}} \div \boxed{1,000} \times \boxed{\phantom{00000}} \\
 \text{Desired Benefit} \qquad \qquad \qquad \text{Rate} \\
 \qquad \qquad \qquad \qquad \qquad \qquad \text{(from table left)} \\
 \\
 \text{Estimated Monthly Payroll Deduction: } \boxed{\phantom{00000}}
 \end{array}$$

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